RESPECT WILL IMPROVE PATIENT OUTCOMES

by Bohringer, Christian, MD | Apr 30, 2019 Leave a comment

When I worked as an anesthesiologist in Australia, my skills and clinical expertise were always treated with the utmost respect. Surgeons and administrators there and in many parts of the world value our knowledge because they realize that the best patient outcomes critically depend on our skills. Australian society in general has a lot of respect for anesthesiology. For example, the Australian government has resisted the introduction of non-physician anesthesia care extenders, despite facing shortages in some geographical areas. There is a frank admission in Australia and New Zealand that administration of an anesthetic carries significant responsibility, requiring very well-trained professionals to optimize patient safety.

My experience in the United States, however has been quite different. I often witness a lack of respect for the skills of anesthesiologists and for the process of administering anesthesia. This manifests as complaints about the anesthesiologist not being immediately available, or excessive "turnover times". By scheduling multiple inductions simultaneously, practice models that include CRNA or resident/fellow supervision are set up for failure. Some surgeons or other staff will remark that the perhaps the attending anesthesiologist does not really need to be present at induction, because a nurse anesthetist can provide the entire anesthetic. Problems with mask ventilation, intubation or anaphylaxis occur more often at the beginning of an anesthetic, so an extra two minutes are usually well worth the wait. In recognition of the fact that these are the most critical times during an anesthetic, the Australia and New Zealand College of Anesthesia requires that the hospital provides a "dedicated assistant to the anesthesiologist" during both the induction and the emergence. An anesthesia tech or an assistant with a similar skillset has to be present during both of these processes.

Unfortunately, I have witnessed other examples of disrespect, including surgeons directing exactly how much and what type of intravenous fluid to give. This often takes place without independent assessment of current clinical signs. This kind of behavior not only disrespects the role of the anesthesiologist but potentially endangers our shared patient by disregarding clinical examination skills and scientific assessment of intra-vascular fluid volume. Adherence to inflexible fluid protocols that are continued in the post-operative period may increase the risk of post-operative acute kidney injury or fluid overload. Unlike other medical specialties, anesthesiologists are experts in assessing the harmonious functioning of all the organ systems, and in prioritizing the needs of some organs over others. Our expertise extends well into the perioperative period, as well as into critical care management and pain management. This fact is recognized by some but not all surgeons and administrators.

Anesthesiologists are critical for the successful implementation of enhanced recovery after surgery (ERAS) protocols. We are essential in helping to gain control over the prescription opioid addiction epidemic. There are currently no protocols that can replace the judgement, clinical acumen, experience, and education of an anesthesiologist. In sick patients, protocols may produce outcomes that are much worse than the results achieved with individually adjusted care by a skilled clinician. Many "early treatment of sepsis" protocols for example, have been associated with increased mortality and morbidity when compared to individualized care.

Why is there such a difference in the respect and value of anesthesiology in the USA compared to the UK, Australia, New Zealand and many European countries? Is it because in the American health care system, anesthetic care may be provided by a nurse with varying degrees of supervision? This devaluation may also extend to other fields. While in many states adequate supervision can be legally provided by a surgeon, most surgeons have never been trained in how to recognize and manage difficult airways. They may not be able to recognize signs of anaphylaxis or myocardial ischemia, excessive sedation versus dehydration, while also performing the operation.

Having a second pair of "educated hands" present during induction and emergence may be ideal but is not always practical. Many physician anesthesiologists in private practice perform with very little back-up. These physicians have a high-level of skill, education and knowledge, and nearly twice the years of training and education than nurse anesthetists. Their sole focus is on their patient's comfort and safety. While it is common to ask and offer advice in certain situations, most anesthesiologists would never consider recommending that a surgeon use a particular type of suture or instrument, and would find it surprising and disrespectful if a surgeon or nurse recommended a particular anesthetic technique, or management style.

We need more of our surgical colleagues to respect our skills and to value our patient care. We also need to make administrators and lawmakers understand that a shared care model, or physician-only practice is much safer for patients than independent practice by nurse anesthetists. In some ORs when a physician anesthesiologist is providing anesthesia alone, there is a "dedicated assistant" available who is knowledgeable about airway equipment. In some institutions this person may be an anesthesia technician, a nurse or a respiratory therapist. This may take some extra resources but could improve patient safety.

In many parts of the world anesthesiologists are in charge or the Operating Rooms (or Theatres) and are much more highly respected than they are in the USA. It is incomprehensible that in this country the same is not true; in the USA anesthesiologists are often caring for equally sick or sicker patients and performing equally complex or more complicated operations. Our training and education are as good as anyone else's in the civilized world and yet many of us continue to experience an ongoing lack of respect.

We have to continue to push for recognition of anesthesiology as a highly technical and important specialty of medicine, and of practitioners who possess high-levels of integrity, dedication, personal responsibility and skill. The American health care system benefits immensely by encouraging and working with the best trained, best educated, most scientifically inquisitive anesthesiologists.

I sincerely believe that an attitude change is necessary within the American health care system. The system needs to learn to respect what anesthesiologists do and this will lead to significant improvements in patient outcomes.

We must all continue to strive to educate our surgeons, administrators, and the public about the intricacies of anesthesia care and the importance of all the additional education and training physicians receive in order to provide the best possible care.

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